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Medicaid Eligibility Quality Control (MEQC)

Phase 1 Sub-Regulatory Guidance

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Medicaid Eligibility Quality Control (MEQC) Program

1. Introduction

The Medicaid Eligibility Quality Control (MEQC) program provides states and the District of Columbia (hereinafter, “states”) a unique opportunity to improve the quality and accuracy of their Medicaid and Childrens’ Health Insurance Program (CHIP) eligibility determinations. The MEQC program is intended to complement the Payment Error Rate Measurement (PERM) program by ensuring state operations make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals.

The MEQC program is executed by states through “pilots” that allow states to evaluate the accuracy of their eligibility determinations, implement prospective improvements, and test the efficacy of corrective actions that are intended to address PERM eligibility errors. The term “MEQC pilot” refers to the process used by states to implement the MEQC program. The MEQC pilots provide states with the necessary flexibility to target specific problems or high-interest areas as necessary. MEQC findings are intended to prompt states to take action to mitigate their risks for improper payments during subsequent PERM review periods and improve the accuracy of their eligibility determinations.

During the pilot studies, states will review a sample of active cases and negative case actions for errors and deficiencies in the case determination process and final results. Where eligibility determinations involving active cases are found to be in error, states will conduct a review of claims paid **for dates of service** in the three months following the **effective date of eligibility triggered by the erroneous** determination. **This “payment review” is intended** to assess the financial implications of the error. After the pilot studies end on December 31, states **will** report their results and develop a CAP for all errors and deficiencies identified. Note that the three-month payment review period may spill over through March of the following year of the MEQC Review Period. A case level report on the pilot results and a CAP are due to CMS on August 1 of the following year (see Table 1).¹

¹ Table 1 also reflects the revised deadlines and streamlined reporting requirements for states’ case level reports, pursuant to changes made in response to the COVID-19 PHE.

A. The MEQC and PERM Programs

The MEQC program is distinct from, but works in conjunction with, the PERM program under 42 CFR 431 Subpart Q. This guidance document is focused on the MEQC program and references the PERM program only as it interacts with the MEQC program. PERM program guidance is outside the scope of this document.

Under the PERM requirements at 42 CFR 431 Subpart Q, the PERM program annually measures the national Medicaid and CHIP improper payment rates using a 17-state three-year rotation process. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all states are captured in one rate. As such, each state is reviewed once every 3 years, and the year in which a state is measured is known as its “PERM year.” A state is not required to conduct a MEQC pilot during its PERM year. When a state is not under PERM review (i.e., in the 2-year interval between a state’s PERM review cycles), the state is required to conduct MEQC activities, including one (1) 12-month MEQC pilot. We refer to this 2-year interval between PERM review periods as PERM “off-years.” During the off-years, the state’s PERM eligibility improper payment rate is frozen for purposes of calculating the national improper payment rate. The MEQC program provides states with the flexibility and opportunity to target eligibility areas of interest during the off-years, including issues found in previous PERM reviews, with the goal of decreasing errors and deficiencies found in subsequent PERM program eligibility reviews.

B. MEQC Background

On July 5, 2017, CMS published a final regulation entitled “Changes to the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) Programs (CMS-6068-F).”² This final rule updated the PERM and MEQC programs based on the changes to Medicaid and CHIP eligibility requirements under the Patient Protection and Affordable Care Act (hereinafter called the Affordable Care Act or ACA). The new regulations restructured the MEQC program into an ongoing series of pilots that states are required to conduct during the two off-years between triennial PERM review years. While states can use the MEQC pilots to address error prone areas identified during past PERM reviews and prepare for upcoming triennial PERM reviews, some additional MEQC requirements exist. One additional

² See 82 FR 31158, <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>.

requirement is to conduct reviews of negative Medicaid and CHIP eligibility determinations as described section 3.F.II below.

C. Organization of this Guidance

This sub-regulatory guidance provides an overview of the MEQC regulatory requirements published on July 5, 2017 (42 CFR 431.800 to 820, also described as 42 CFR 431 Subpart P). It provides special emphasis on the factors of eligibility and processes of eligibility that states should consider in conducting their MEQC pilots. It also provides in-depth detail about the requirements of state MEQC pilot planning documents.

A future sub-regulatory guidance update is planned to discuss the requirements of the case level reports and corrective action plans (CAPs) that states must submit at the conclusion of each pilot (based on the requirements of 42 CFR 431.816 and 431.820, respectively). The updated sub-regulatory guidance will come with an electronic version of the reporting template. It will contain instructions on how to complete all fields on the various worksheets along with where to submit the reports.

D. Procedures for Updates to this Guidance

This document will be updated and expanded as needed. Please refer to the cover page to see the date this document was most recently updated. When the document is updated, substantive changes will appear in red font for one update cycle.

2. Definitions³

- ***Active case*** – A selected individual determined to be currently authorized as eligible for Medicaid or CHIP by the state, to be reviewed for correct eligibility determination.
- ***Corrective action*** - Action(s) to be taken by a state to reduce major error causes, trends in errors or other vulnerabilities for the purpose of reducing improper payments in Medicaid and CHIP.

³ The definitions in this section, with the exception of “negative case errors,” mirror 42 CFR 431.804. Italicized paragraphs in this section represent further clarifications and explanations that go beyond the language in the regulation. We have also added several useful definitions for terms that are not found in the MEQC regulation. These include “federal financial participation” (FFP), “payment review,” “qualified entity,” and “targeted enrollment.”

- **Deficiency** - A finding in processing identified through active case review or negative case review that does not meet the definition of an eligibility error.

Deficiencies involve improper application of eligibility rules made in active or negative case determinations that do not have financial consequences. For example, if a state samples a case and finds it has erroneously placed a beneficiary in an incorrect Medicaid eligibility category but this mistake did not affect the beneficiary's ability to obtain medically necessary covered services or the federal or state share of Medicaid payments, it would be cited as a deficiency in state reporting on MEQC cases. Note that placing a Medicaid-eligible beneficiary in CHIP rather than Medicaid may have financial consequences.

- **Eligibility** - Meeting the state's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.
- **Eligibility error** - An error resulting from the states' improper application of Federal rules and the state's documented policies and procedures that causes a beneficiary to be determined eligible when he or she is ineligible for Medicaid or CHIP, causes a beneficiary to be determined eligible for the incorrect type of assistance, causes applications for Medicaid or CHIP to be improperly denied by the state, or causes existing cases to be improperly terminated from Medicaid or CHIP by the state. An eligibility error may also be caused when a redetermination did not occur timely or a required element of the eligibility determination process (for example income) cannot be verified as being performed/completed by the state.

In contrast to deficiencies, eligibility errors made with reference to Medicaid or CHIP applications or redeterminations have financial consequences that result in actual or potential overpayments or underpayments. Generally, as described below (see definition below and section 4.h.VI.b), states will be expected to conduct "payment reviews" for all erroneous eligibility determinations involving active cases in order to determine whether their Medicaid or CHIP Programs paid too much or too little federal financial participation (FFP) as a result of the errors (overstated or understated liability).

- **Federal financial participation (FFP)** - The federal government's share of the state's expenditures under the Medicaid program and CHIP.

- **Medicaid Eligibility Quality Control (MEQC) program** - A program designed to reduce erroneous expenditures by monitoring eligibility determinations and work in conjunction with the PERM program established in *42 CFR 431, Subpart Q*.
- **MEQC pilot** - Refers to the process used to implement the MEQC program.
- **MEQC review period** - The 12-month timespan from which the state will sample and review cases.
- **Negative case** - A selected individual denied or terminated eligibility for Medicaid or CHIP by the state, to be reviewed for correct eligibility determination.

Negative case errors⁴ are errors, based on the state's documented policies and procedures, resulting from either of the following:

- (i) Applications for Medicaid or CHIP that are improperly denied by the state.*
- (ii) Existing cases that are improperly terminated from Medicaid or CHIP by the state.*

- **Off-years** - The scheduled 2-year period of time between a states' designated PERM years.
- **Payment Error Rate Measurement (PERM) program** - The program set forth at *42 CFR 431, Subpart Q* utilized to calculate a national improper payment rate for Medicaid and CHIP.
- **Payment Review** - *A required review of improper payments made on behalf of active cases with incorrect eligibility determinations, to be conducted by the state in accordance with the instructions in this sub-regulatory guidance document.*
- **PERM year** - The scheduled and designated year for a state to participate in, and be measured by, the PERM Program set forth at *42 CFR 431, Subpart Q*.
- **Qualified entity** - An entity that is determined by the state to be capable of making determinations of presumptive eligibility and furnishes eligibility under the approved state plan.

⁴ As defined in *42 CFR 431.812(d)*

- **Targeted Enrollment** - A strategy designed to facilitate enrollment of eligible individuals in Medicaid/CHIP.

3. MEQC Program Operations

A. Required Activities and Timing

Each state is required to conduct an MEQC pilot in the two years between the state’s PERM review periods. A pilot includes the following components:

- A state planning document that must be reviewed and approved by CMS
- Case reviews during the MEQC review period
- State reporting, including:
 - Case-level report on the findings of these reviews, and
 - Corrective action plan (CAP)

Table 1 below reflects the timing of these required deliverables and activities.

Table 1: MEQC Program Activities by PERM Cycle

PERM Cycle*	PERM Review Period	MEQC Pilot Planning Document Due to CMS	MEQC Review Period	MEQC Case-Level Report on Findings and CAP Due to CMS
Cycle 1	July 1, 2017 - June 30, 2018	November 1, 2018	January 1 - December 31, 2019	Nov. 1, 2020**
Cycle 2	July 1, 2018- June 30, 2019	November 1, 2019	January 1 - December 31, 2020	Nov. 1, 2021**
Cycle 3	July 1, 2019 - June 30, 2020	November 1, 2020	January 1 - December 31, 2021	Nov. 1, 2022**

*see Appendix 5 for a list of states by PERM Cycle

****NOTE:** As a result of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), CMS established revised deadlines and streamlined reporting requirements for states’ case level reports. The revised deadlines and reporting requirements have been published in Section II of the supplemental guidance document that is available on the MEQC website, at <https://www.medicare.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>.

B. Federal Support for MEQC Activities

States must claim federal funding for their MEQC pilot activities under the Medicaid administrative match or under CHIP's 10 percent administrative cap, based on the workload of cases undertaken in each program. All federal match questions should be directed to a CMS Division of Financial Operations representative that serves their state. These representatives work in the Financial Management Group (FMG) in CMS' Center for Medicaid and CHIP Services (CMCS). The FMG oversees staff working on Medicaid financial management and claiming issues. If states have questions about who their Medicaid financial management specialists are, they may contact the MEQC mailbox (CMS-MEQC-Inquiries@cms.hhs.gov) for assistance.

C. MEQC Review Staff

I. Use of Contractors

States may utilize state staff (including existing MEQC/PERM review staff, within certain parameters) or contractors to fulfill pilot requirements.

II. Reviewers: State Assurance of Independence

To avoid potential conflicts of interest during the MEQC case reviews, 42 CFR 431.812(a) requires that the agency and personnel responsible for the development, direction, implementation, and evaluation of the MEQC reviews and associated activities must be functionally and physically separate from the state agency and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations. To meet this requirement, CMS requires states to describe in the pilot planning documents how the MEQC reviewers will maintain independence and objectivity. In addition to the narrative description, CMS also requires states to submit organizational charts verifying the functional separation of staff and responsibilities.

If a state has an organizational structure allowing MEQC personnel to be "functionally and physically separate" from the state agency and personnel responsible for Medicaid and CHIP policy and operations, then the state would meet the regulatory requirement described in 42 CFR 431.812(a).

However, not all states' organizational structures match the organizational structure described in the regulatory requirement. Specifically, states may operate a single state agency such that there

is not a separate state agency in which the MEQC pilots could be conducted. In this situation, such states may meet the regulatory requirement described in 42 CFR 431.812(a) by implementing the following organizational arrangements, as applicable:

- (1) There must be at least two (2) levels of separation of authority between the MEQC personnel and the Medicaid and CHIP policy and operations personnel before such personnel fall under the authority of the same higher level manager or senior executive.
- (2) If a state cannot document the required two (2) levels of separate supervisory authority, the state may develop a Memorandum of Understanding (MOU) within the single state agency that will allow for the preservation of the independence of MEQC personnel. In the MOU, the state should describe how it will ensure that the MEQC personnel preserves its independence by reporting to a higher managerial level within the state agency or by having the ability to refer possible disputes for adjudication at this higher level. The MOU should be signed by the appropriate supervisors and managers from the affected parties to confirm that the arrangement is in place.

An example of an MOU template is included in Appendix 6. If a state pursues the MOU arrangement, the MOU should be sent to: CMS-MEQC-Inquiries@cms.hhs.gov.

D. MEQC Pilot Planning Document

Under § 431.812(a), MEQC pilot studies must be conducted in accordance with an approved pilot planning document.

Under § 431.814, states must submit an MEQC pilot planning document to CMS for approval by November 1 of the same year in which the state's PERM review ends. As noted in Table 1 above, the planning documents for the PERM Cycle 1, 2, and 3 states are due on November 1, 2018, November 1, 2019, and November 1, 2020, respectively.

I. MEQC Pilot Planning Document: Specific Requirements

The MEQC pilot planning document should be no longer than 20 pages. The general instructions for what to include in the pilot planning document can be found at 42 CFR 431.814. This guidance document provides further elaboration on those instructions.

All pilot planning documents must include an organizational chart showing where state MEQC reviewers are housed and a discussion of how MEQC reviews are able to function independently of components that establish Medicaid eligibility policy and make eligibility determinations.

For active case reviews, pilot planning documents must include:

- A discussion of what, if any, areas of focus in Medicaid and CHIP the reviews will have as well as a justification for any targeted areas;
- A description of the universe development process;
- Information on the sample size per program (Medicaid and CHIP as well as any areas of focus);
- A discussion of the sample selection methodology;
- A description of the case review process (see discussion in section 3.F. below); and
- A description of the payment review process to be undertaken for active cases in which errors are found

For negative case reviews, pilot planning documents must include:

- A description of the universe development process;
- Information on the sample size per program (Medicaid and CHIP);
- A discussion of the sample selection methodology; and
- A description of the case review process (see discussion in section 3.F. below)

Appendix 2 includes a template for states to use in compiling their planning documents to help ensure that the necessary content is included.

Appendix 3 contains a cover sheet that states must complete as an executive summary for their pilot proposals.

Appendix 4 contains specific instructions for completing the cover sheet/executive summary.

States must submit their planning documents electronically to CMS's MEQC mailbox at: CMS-MEQC-Inquiries@cms.hhs.gov. All documents submitted should include the following information for the state MEQC coordinator:

- Name
- Title
- Full mailing address
- Email
- Phone number(s)

II. MEQC Planning Document: CMS Review and Approval

The initial MEQC planning document must be submitted to CMS no later than November 1 of the same year in which the PERM review period ends on June 30.

CMS will communicate electronically with the designated state MEQC coordinator. Within 15 business days of CMS' receipt of the MEQC planning documents, the state MEQC coordinator will receive either an approval or a request for additional information. In the event additional information is requested, the state will have 10 business days in which to respond to questions and amend their planning documents as needed. Within 15 business days of receipt of additional information, unless there are unusual issues or concerns with a specific MEQC planning document requiring additional review, a final approval of the planning document will be issued, along with a hard copy of the signed approval letter. States must receive electronic notification of CMS' approval in order to begin an MEQC pilot study.

E. MEQC Pre-Review Activities

I. Medicaid and CHIP Sample Universes

As shown in Table 1, the MEQC review period runs from January 1 through December 31 of the year that follows the submission of the MEQC pilot planning document. In most cases, states will pull their samples for this full time period; however, it is possible that a state would pull their samples for a narrower time period within the review period when appropriate.

The sampling unit in the MEQC pilots is the individual eligibility determination, or "case." In establishing complete universes of Medicaid and CHIP cases to sample, states should identify, for each program, all active cases in the calendar year corresponding to their MEQC review period (see Table 1). If more than one approval or renewal occurred during the sampling timeframe, the most recent action that occurred should be reviewed, not all activity that occurred during the sampling timeframe. There are some exceptions to this, as detailed below in section F.1.

States should subsequently exclude from the Medicaid and CHIP universes cases that are not eligible for MEQC review. There are three types of cases that should be excluded:

- Express Lane Eligibility (ELE) cases: a separate analysis of ELE cases will be undertaken in states that have taken this option under Section 203 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.⁵
- Any cases that are supported by state-only funding.
- Cases that are under ongoing fraud investigations.⁶

States should make provisions for oversampling in their pilot planning documents in order to account for possible cases that meet the above exclusion criteria or that may otherwise be invalid.

In addition to establishing separate universes for active Medicaid and CHIP cases, states may choose to further stratify their sample universes to support the targeting of cases from specific areas of focus. To support stratified sampling, subgroups may also be established within the active case Medicaid universes, based upon, for example:

- Categories of eligibility (mandatory or optional)
- Modified Adjusted Gross Income (MAGI),⁷ such as:
 - Adult expansion group
 - Parents/Caretaker Relatives
 - Pregnant women
 - Infants and children under age 21
- Non-MAGI-based, such as:
 - Supplemental Security Income (SSI) beneficiaries
 - Medically fragile populations
 - Nursing home residents
 - Beneficiaries in home and community-based services programs

States have the option of reviewing an entire subgroup without sampling if this is feasible. Stratified sampling within the CHIP universe is also permissible. For example, states that expanded coverage under title XXI through both a separate CHIP and through a Medicaid expansion program may wish to include cases from both programs. States may also wish to

⁵ Express Lane Eligibility (ELE) is a CHIPRA option that allows states to enroll children into Medicaid or CHIP based on information available through other benefit programs and databases.

⁶ See the requirements for beneficiary and provider fraud investigations at 42 CFR 455 Subpart A.

⁷ Modified Adjusted Gross Income (MAGI) is defined at 26 CFR 1.36 B-1(e)(2) and applied to certain Medicaid and CHIP eligibility determinations at 42 CFR 435.603(e).

focus on pregnant women and/or children from conception to birth, to the extent a state provides coverage for those eligibility groups.

a. Sample Universe: Quality Control Procedures

In identifying the overall universe of case determinations and selected subgroups, we recommend that states perform quality control checks within the sampling time frames to ensure completeness and accuracy. Some examples of quality control checks include (but are not limited to):

- Selecting a preliminary test sample to ensure excluded cases have been removed from the universe
- Comparing the total count of pilot determinations in the overall universe (and total count of pilot determinations for each subgroup, if applicable) against existing benchmarks, such as official state enrollment reports, to assess reasonableness and completeness prior to sampling
- Reviewing total determinations (and subgroup totals, if applicable) in each month of the sampling timeframe to identify inconsistencies from month to month

II. Case Sampling

Regarding sampling requirements, under § 431.812(b) and 431.812(c), states must review a sample of at least 400 active and 400 negative cases.⁸ Within these totals, specific minimum numbers of Medicaid and CHIP cases must be sampled. Table 2 provides further detail. States have the discretion to sample higher numbers of cases than the minimum thresholds specified in the regulation. **Although states are not required to select statistically valid samples, any samples selected for Medicaid and CHIP reviews, including focused reviews of active cases (see below), should be chosen on a randomized basis.**

⁸ **NOTE:** As a result of the COVID-19 PHE, CMS established reduced sample sizes for the Cycle 2 and Cycle 3 states (January 1, 2020 – December 31, 2020 and January 1, 2021 – December 11, 2021 review years, respectively). The reduced sample sizes have been addressed in Section I of the supplemental guidance document that is available on the MEQC website, at <https://www.medicaid.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>.

Table 2: Minimum* MEQC Sampling Requirements under § 431.812

	Medicaid Program Sample	CHIP Sample	Total***
Active Cases	200	At state's discretion**	400
Negative Cases	200	200	400

*States may opt to review larger samples.

**States' discretion to sample fewer CHIP active cases takes into consideration that a state's CHIP sample universe may be smaller than its corresponding Medicaid program sample universe. Although there are no minimum sampling requirements for active CHIP cases, CMS strongly recommends that states include CHIP cases in their review of active cases. If a state chooses to sample no active CHIP cases, a justification for this must be provided in the planning document. State discretion regarding the number of CHIP active cases to sample does not alter the MEQC requirements for the total number of active cases that must be sampled. For example, if a state, based upon its sample universe sizes and MEQC program goals, determines that its active CHIP case sample target is 100, the state must sample at least 300 active cases from the Medicaid universe to meet the required combined Medicaid-CHIP total of 400 active cases reviewed.

*** **NOTE:** As a result of the COVID-19 PHE, CMS established reduced sample sizes for the Cycle 2 and Cycle 3 states (January 1, 2020 – December 31, 2020 and January 1, 2021 – December 31, 2021 review years, respectively). The reduced sample sizes have been addressed in Section I of the supplemental guidance document that is available on the MEQC website, at <https://www.medicaid.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>.

F. MEQC Case Review Activities

I. Active Case Reviews

For case reviews where an individual has been determined eligible for Medicaid or CHIP by the state, this section discusses active case review requirements and considerations.

As noted in section E.I. above, a complete Medicaid or CHIP universe will include all active cases or persons eligible for these programs during the MEQC review period. If a state chooses to perform active case reviews with a selected area of focus (see below), the universe will consist of all active cases pertaining to each chosen area of focus. Whether sampling from the entire active case universe or from the active cases in a specific area of focus, the state must pull a random sample from a list of all relevant cases that were active during a designated sampling timeframe. This will involve pulling samples on either a monthly or quarterly basis throughout the review year.

If the sample pulled by a state shows that more than one affirmative eligibility determination for an individual was made in the past year, only the most recent action (i.e., approval or renewal) should be the focus of the review. However, when renewing redeterminations necessitated by a change in circumstances, MEQC reviewers should consider whether the change was a minor one, such as a reported change of address, that did not require a review of all major factors of eligibility, electronic data sources, and the like. If the reported change was minor, then the MEQC reviewers should go back to the last approval or redetermination that considered all aspects of the applicant's or beneficiary's eligibility.

a. Areas of Focus for Active Case Reviews

Under § 431.812(b)(3)(ii), if the eligibility component of a state's PERM improper payment rate is above the 3 percent national standard for two consecutive PERM cycles, CMS may require that state MEQC pilots include specific active case review components. However, as long as a state's PERM improper payment rate remains at or below the 3 percent national standard, §431.812(b)(3) provides states with the discretion to choose the eligibility groups or issues on which to focus for MEQC. Per the regulation, states may propose to focus active case reviews on:

- Recent changes to eligibility policies and processes
- Areas where the state suspects vulnerabilities
- Proven error-prone areas

Appendix 1 sets forth potential subject areas for MEQC reviews.

b. Examples

If a state knows or suspects that there are issues with eligibility determinations in a new coverage group, such as the Medicaid adult expansion group, for example, this would be an appropriate subject for a focused MEQC review. Such a study might pay special attention to whether or not the agency is appropriately identifying newly eligible adults, for whom services will be reimbursed at an enhanced Federal Medical Assistance Percentage (FMAP) rate, and non-newly eligible adults whose services are reimbursed at the state's regular FMAP rate. This type of focused review could be especially helpful to the more recent Medicaid expansion states under ACA, which have the least experience serving the new population.

Likewise, states that know or suspect issues with other segments of the Medicaid population, such as the high-cost nursing home population, should consider these subgroups as possible topics for areas of focus.

States may also consider areas of focus that look at important factors of Medicaid and CHIP eligibility. Recent CMS oversight efforts and reviews have identified state compliance with verification plans and procedures as an error prone area for several states. CMS encourages states to review verification procedures in areas where verification is required either by law (such as citizenship and immigration status or asset verification) or by the states' verification plans.⁹

For example, if the application process initially relies on self-attestation with post-enrollment verification processes for applicants determined eligible based on certain attested information, a review might focus on how such attestations were subsequently reviewed and verified, either by using information from trusted third party sources or by using documentation provided by the applicant/beneficiary. The review could include determining whether income reported or attested to by an applicant or beneficiary was reasonably compatible with the income listed in an electronic data source based upon the compatibility threshold identified in the state's verification plan.¹⁰ The case record should indicate what methods were used to verify citizenship or immigration status as required by law, as well as attestations regarding income, noting whether documentation confirmed (or did not confirm) the attestations, and when in the application process confirmation or non-confirmation was received. For instance, states should be able to document that post-eligibility verification of citizenship and immigration status occurred within 90 days of an eligibility determination.¹¹

Similarly, in presumptive eligibility (PE) cases, states could look to see if complete applications were submitted within the PE period, which generally ends on the last day of the month after a PE determination was made.

II. Negative Case Reviews

Negative case actions are determinations where eligibility for a new applicant is denied for Medicaid or CHIP, or eligibility is terminated for a beneficiary in Medicaid or CHIP. While

⁹ 42 CFR 435.945(j) and 457.380(j), require states to develop, and update as modified, a Medicaid/CHIP verification plan describing the verification policies and procedures adopted by the agency in accordance with §435.940-435.965, and §457.380.

¹⁰ See 42 CFR 435.945(a)(i).

¹¹ See 42 CFR 435.956(b)(2)(ii)(A).

negative case reviews are not included in PERM reviews, the review of negative case actions is required under the MEQC pilots.

States should establish complete universes of negative Medicaid and CHIP cases from which to pull a random sample by identifying all negative case actions for each program that occurred during the MEQC review period (see Table 1). **If a state were sampling negative case actions on a monthly or quarterly basis, it should pull its random sample from all the denials and terminations that occurred in each month or quarter in the review year.** If more than one negative case action for an individual occurred during the state's sampling timeframe, only the most recent denial or termination should be the focus of the review.

a. Requirements for Negative Case Reviews

In contrast to their review of active case determinations, states do not have authority to focus on specific eligibility groups or elements of the determination process that cut across multiple groups when reviewing negative case actions. States must instead **randomly** sample a minimum of 200 Medicaid and 200 CHIP cases from the entire universe of negative Medicaid and CHIP cases, respectively, that are identified during the MEQC review period.

b. Other Considerations for Negative Case Reviews

Although cases must be selected from the entire negative case universe, while conducting their reviews, states may want to pay special attention to whether certain types of negative case actions are prone to error or deficiency. For example, the most recent PERM findings have found the improper placement of children in CHIP who should have been eligible for Medicaid to be a significant driver of the CHIP eligibility improper payment rate in PERM. States should also review whether individuals were appropriately considered for all possible MAGI as well as non-MAGI eligibility groups before denials or terminations occurred. States should likewise pay close attention to whether timely issuance and filing of notices took place.

Particularly in states with separate MAGI and non-MAGI eligibility systems, CMS oversight efforts show that states should check to see that individuals found ineligible for MAGI eligibility groups are referred to the non-MAGI eligibility system when appropriate, so that such individuals do not have to apply for Medicaid again to be evaluated for a non-MAGI eligibility group.

In addition, states should classify errors they find in negative case determinations in a manner that will assist state personnel with developing effective CAPs. For example, states might consider the following classifications, among others:

- Denials or terminations based on the misapplication of eligibility-related criteria
- Denials or terminations based upon procedural reasons
- Human error versus system error

Lastly, in developing their studies of negative case actions, states may want to look for commonalities in denials and terminations that were overturned in the Medicaid fair hearing or CHIP review process and the reasons why such appeals were not upheld. A pattern analysis of this type may point states in the direction of issues or program areas worth studying as part of the negative case action review.

States will define the negative case actions as erroneous if, based on documented state policies and procedures, applications for Medicaid or CHIP are improperly denied, or existing Medicaid or CHIP cases are improperly terminated.

In general, most of the elements in Tables 3 and 4 below can be considered in reviewing negative case actions as well as active cases, although some may not apply and some will have different implications when considering Medicaid vs. CHIP or MAGI vs. non-MAGI cases.

III. Duplicate Cases Appearing in Multiple Sampling Universes

There are a number of scenarios in which the same case might appear in different sampling universes (known as duplicate cases). Examples of this scenario include, but are not limited to, the following:

- A Medicaid beneficiary (active case universe) reports a change in circumstance that leads to their termination (and subsequent inclusion in the negative case universe)
- A Medicaid beneficiary enrolled in the MAGI category is subsequently terminated and enrolled in a non-MAGI category. If the state were doing separate focused reviews of MAGI and non-MAGI beneficiaries, the beneficiary might appear in both active case universes, while the closure of the MAGI case would also place the beneficiary in the negative case universe. The MEQC reviewer's task would be to determine whether the closure of the MAGI case was appropriate, or if the most recent action in the non-MAGI case is correct, depending on the specific universe from which the sample was selected
- Children under the age of 19 can be denied Medicaid but approved for CHIP (or vice versa). Such children would likely be included in the negative universe of the program

for which they were denied but in the active case universe of the program for which they were approved

- A number of states have reported that the state is unable to distinguish Medicaid and CHIP denials for children because the eligibility process automatically evaluates children for eligibility in both programs. In such states, in cases of the denial of eligibility in both programs, CMS recommends that the children be included in both the Medicaid and CHIP negative universes. If a child in this scenario is selected from the negative Medicaid universe, the MEQC reviewer would evaluate the denial based on that state's Medicaid criteria and income standards. Alternatively, if selected from the negative CHIP universe, the MEQC reviewer would evaluate the denial based on that state's CHIP criteria and income standards

When sampling from a single universe, states may discard a case as a duplicate if the case is picked two or more times for a review of the same action taken. However, if the same case is sampled at different intervals and the MEQC reviewer finds that two or more different actions have occurred, each action may be reviewed and counted separately as part of the required MEQC workload. This also applies when the same cases are sampled from different universes, as described above.

IV. Review Procedures

a. MEQC Case Review: Design

After the pilot planning document has been approved and sample selections are made, the MEQC review staff should begin conducting eligibility reviews that take into account state and federal policy to identify the accuracy of the eligibility determinations. When considering how to design the review protocol, MEQC review staff should also consider internal and external processes that, while not resulting in eligibility determination errors, may result in deficiencies that need to be addressed through corrective actions.

The eligibility case review should focus on the following:

- Whether a caseworker or eligibility system made the correct eligibility determination based upon information available at the time of the decision
- Whether an eligibility IT system's logic (as applicable) processes case information appropriately, including whether the system verifies information in data sources

- In situations where the eligibility system was overridden by the caseworker, whether the caseworker’s actions were correct
- Whether electronic data sources were checked and utilized, where available, before paper documentation was requested

V. Case-Level Reviews

a. Eligibility Elements and Processes

The state’s case review should be a comprehensive review that includes all of the elements described below and any additional elements the state uses to determine the appropriate program, the appropriate eligibility sub-group, and whether the eligibility determination process was undertaken correctly. At a minimum, the eligibility criteria in Table 3 should be considered when reviewing cases for the accuracy of eligibility determinations. States should also include information for any additional review elements that are not included in Table 3.

Although states will review household composition and household income in order to assess whether an individual’s eligibility was correctly determined, states need not ascertain the eligibility of each member of the household. The state must review all elements necessary to evaluate the correctness of overall program eligibility as well as the eligibility category only for the individual whose eligibility determination is under review.

Table 3: Eligibility Criteria (Elements): Considerations for Review

Eligibility Criteria	Considerations
Income	<ul style="list-style-type: none"> • Was the state's reasonable compatibility standard, as specified in the verification plan, followed? • Were income calculations correctly made based on MAGI vs. non-MAGI? • Was the individual placed in the appropriate eligibility group based on income?
Residency	<ul style="list-style-type: none"> • Was residency verified in accordance with state policies, including the state verification plan?

Age (Date of Birth)	<ul style="list-style-type: none"> • Was age verified in accordance with state policies, including the state verification plan? • Was the individual placed in the appropriate eligibility group based on age? • Was the individual placed in managed care or a managed care plan based on age?
Gender ¹²	<ul style="list-style-type: none"> • Was the individual placed in the appropriate eligibility group based on gender?
Social Security Number	<ul style="list-style-type: none"> • Were state and federal policies followed in verifying the applicant's SSN?
Citizenship and Immigration Status	<ul style="list-style-type: none"> • Was citizenship/immigration status verified in accordance with state and federal policies? • If applicable, did the state appropriately apply the reasonable opportunity period policy?
Household Composition	<ul style="list-style-type: none"> • Was the household composition constructed properly? • Was the income of all individuals appropriately included in or excluded from the household?
Pregnancy Status	<ul style="list-style-type: none"> • Was the individual placed in the appropriate eligibility group based on pregnancy status?
Caretaker Relative	<ul style="list-style-type: none"> • Was the individual placed in the appropriate eligibility group based on caretaker relative status?
Medicare	<ul style="list-style-type: none"> • Was Medicare status determined appropriately? • Was the individual placed in the appropriate eligibility group (e.g., Medicare Savings Program) based on Medicare status?
Application for Other Benefits	<ul style="list-style-type: none"> • Was the individual eligible to apply for other benefits (such as Social Security, unemployment compensation, etc.)? If so, was the applicant referred to apply for those benefits?¹³

¹² Gender is itself not a categorical eligibility requirement for state plan eligibility groups/categories. However, gender can be a factor of eligibility for certain section 1115 family planning demonstrations.

¹³ See 42 CFR 435.608, Applications for other benefits.

(a) As a condition of eligibility, the agency must require applicants and beneficiaries to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.

(b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

Other Coverage (CHIP only)	<ul style="list-style-type: none"> • If the state has a waiting period, was the requirement met?
Assets (For non-MAGI only)	<ul style="list-style-type: none"> • Were appropriate assets included/excluded from the state's calculation? • Was the individual placed in the appropriate eligibility group based on assets? • Were assets appropriately verified in the Asset Verification System (AVS)?
Transfer of Resources and Expenses (For non-MAGI only)	<ul style="list-style-type: none"> • Did the state ask for appropriate documentation related to resource transfers? • Was the individual eligible based on resource transfer criteria?
Medical Eligibility Requirements	<ul style="list-style-type: none"> • Did the state ask for appropriate medical eligibility documentation? • Was the individual eligible based on medical eligibility requirements?
Spend Down Expenses	<ul style="list-style-type: none"> • Did the state ask for appropriate documentation for expenses for the budget period elected by the state when calculating spend down for medically needy or 209(b) status?
Long-Term Care Specific Information (e.g., look back period assessment, spousal share, Miller Trust, etc.)	<ul style="list-style-type: none"> • Did the state review 60 months of statements from all financial institutions found through the AVS or reported on the application as well as other resource information to determine countable assets and whether a penalty period should apply due to a transfer? • If the applicant has a spouse, did the state gather the asset information for both individuals, and <ul style="list-style-type: none"> • Look for transfers (but bearing in mind that not all transfers result in a penalty period), and; • Determine the spousal share of assets allowable for the community spouse? • Did the state review any Miller trusts, special needs, or pooled trusts when determining eligibility to determine whether the transfer to the trust is allowable? • Did the state properly calculate a personal needs allowance from the applicant/beneficiary's income?

FFP	<ul style="list-style-type: none"> • Is the individual placed in the appropriate “FFP category”? • Was the correct FFP claimed?
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For each of the eligibility criteria listed in the table above, states are required to provide the following information in the pilot planning document:

- Information regarding case-level data elements to be reviewed
- Information regarding data elements to be reviewed from the eligibility screen
- Information regarding how compliance with verification plan or AVS requirements will be reviewed
- Any additional criteria for eligibility review processes

Reviewers should also consider the process considerations in Table 4 below.

Table 4: Eligibility Processes: Considerations for Review

Process Findings	Considerations
Notices for Active and Negative Cases	<ul style="list-style-type: none"> • Were appropriate notices sent for both active and negative cases that included all required and accurate information? • Were notices sent in a timely manner?
Denial and Termination Transfers	<ul style="list-style-type: none"> • Were children and pregnant women who were denied or terminated from Medicaid evaluated for a separate CHIP, if applicable? • For states utilizing the federally facilitated exchange (FFE): <ul style="list-style-type: none"> ○ Were denied or terminated cases transferred to the FFE appropriately for determination of Advance Premium Tax Credit and Cost Sharing Reduction for a qualified health plan? • For states utilizing a state-based marketplace (SBM): <ul style="list-style-type: none"> ○ Were denied or terminated cases considered appropriately for determination of Advance Premium Tax Credit and Cost Sharing Reduction for a qualified health plan ? • For states utilizing either the FFE or an SBM: <ul style="list-style-type: none"> ○ Were individuals aging out of the adult group appropriately evaluated for Medicare Savings Programs or other Medicaid eligibility categories?

Transfers from FFE/SBM	<ul style="list-style-type: none"> • If the application was transferred from the FFE or SBM, was information evaluated appropriately in accordance with the state’s assessment/determination state status and its verification plan?
Caseworker action	<ul style="list-style-type: none"> • If both system edits and/or caseworker actions were part of the eligibility determination process, were they effectuated correctly? When necessary, was the caseworker’s action correct and appropriate (including override of the system’s business rules)? • For system actions where information was received manually from an outside entity, was the information entered into the system appropriately and timely?
Applicant Information Requests	<ul style="list-style-type: none"> • When conducting verifications, did the system/caseworker attempt to locate electronic third party data sources as required by the regulations? Did the caseworker adhere to the state’s verification plan and/or query electronic data sources, such as the IRS, the state’s quarterly wage database, the AVS (for non-MAGI cases only) or Department of Motor Vehicles, for verifications before requesting paper verifications from the applicant or beneficiary?
Timeliness	<ul style="list-style-type: none"> • Was case processed within the required state and federal timeframe? • Was renewal conducted in last 12 months?

States should be clear in the planning document that the criteria review information submitted will thoroughly address all aspects of the eligibility determination process. States can provide lists of general information that will be reviewed for each eligibility criterion (element). States should not provide a detailed list of every possible source of information.

All elements may have different implications for Medicaid vs. CHIP or MAGI vs. non-MAGI cases. Similarly, not all required review elements apply to both active and negative cases or to both initial determinations, **annual** redeterminations, **and unscheduled redeterminations based on changes in beneficiary circumstances.**

In general, reviewers will evaluate each case for all required eligibility criteria to confirm that the state made the appropriate determination of eligibility, given the information available on the

application, from trusted third party data sources, and via hard copy documentation, as applicable. This includes the following:

i. Review against Federal and State Guidance and Policies

In making determinations, states should use the following sources of policy as a frame of reference:

- CMS-approved State Plan
- State and federal regulations
- State policy and procedure manuals
- MAGI-Based eligibility verification plan and amendments
- Approved waivers and mitigation plans
- Federal guidance
- Memoranda
- Application forms and other standardized forms

ii. Review of Calculations

For system actions where calculations (e.g., income, household composition) were conducted as part of the determination, the reviewer should independently review the information used by the system and determine if calculations were done correctly. The reviewer should manually calculate income and household composition to evaluate whether the calculation performed by a caseworker or system was correct.

iii. Review of Third Party Data

For systems actions where data or information used to determine eligibility is received from an external source, the review should include making a determination regarding whether the external information was entered in the system or factored in the determination appropriately and timely.

Regarding third party data used to verify self-attested information that was included on the application, the review should include determining whether system actions or interactions appropriately considered the data in accordance with the state's verification plan and other state and Federal policies.

iv. Review of Paper Verifications

When determining eligibility, the eligibility system or caseworker should solicit and rely upon available third party data prior to requesting paper documentation from a prospective beneficiary. If the caseworker made a correct eligibility determination but did not follow the state's verification plan, for example by requesting paper verifications without attempting to obtain verifications electronically, this action will be identified as a deficiency.

v. Review of Eligibility Category for Active Cases

Upon finding an active case was determined correctly, the reviewer should further determine whether an individual was placed into the correct eligibility category.

vi. Review of Subsequent Action for Negative Cases

Upon finding a negative case was determined correctly, the reviewer should further determine whether the individual was appropriately transferred to the SBM or FFE.

vii. Review of Manual Override Cases

In situations when a caseworker overrides system logic to enter information manually, the reviewer should determine whether the caseworker's actions occurred timely and appropriately. The state should likewise report, as a finding, when a caseworker override should have occurred but did not occur.

viii. Review for Timely Action

The reviewer should determine whether an eligibility determination was made within the allowable timeframes (see 42 CFR 435.912(c)(3) for Medicaid and 42 CFR 457.340(d) for CHIP).

VI. Communication with Beneficiaries or Individuals Denied for Coverage

States should not contact beneficiaries as part of their MEQC pilot reviews. Rather, reviewers should rely on the evidence available in case records when deciding whether eligibility determinations or negative case actions involved errors or deficiencies or whether, based on the available documentation, it could not be determined if a case was adjudicated correctly.

That said, after the state’s MEQC pilot is complete, state personnel may follow up with beneficiaries while undertaking corrective actions and root cause analyses in certain situations.

VII. MEQC Findings: Payment Review¹⁴

Where eligibility determinations involving active cases are found to be in error, states will conduct a review of paid claims for services provided in the three (3) months following the effective date of eligibility that was triggered by the erroneous determination. The payment review will be undertaken to assess the financial implications of the error, and any identified overpayments should be returned to CMS as described below.

a. Approved Medicaid Management Information System (MMIS)

Under § 431.806(d), states must have an approved Medicaid Management Information System (MMIS) under 42 CFR 433 Subpart C in order to undertake the payment review piece of their pilot studies. If a state does not have a certified MMIS, it must otherwise have a Medicaid quality control claims processing assessment system that meets the requirements of § 431.830 through § 431.836.

b. Payment Review Process:

States are required to undertake a payment review of those sampled active cases in which errors resulted in a possible overpayment or underpayment. In general, the payment review should look for paid claims for dates of service that occurred in the first three (3) months after the effective date of eligibility that was triggered by the erroneous eligibility determination. The three month payment review period could include a period of up to three months of retroactive Medicaid coverage for which beneficiaries may be eligible, per the requirements of 42 CFR 435.915. The payment review should look at all claims for dates of service that fall within the three-month payment review period. It should not confine itself to looking only at claims that were paid within this timeframe. Because providers may often submit Medicaid claims for up to a year or more after the date of service, states should be aware of the relevant look-back period that will be required for the payment review. How long the look-back period for possible

¹⁴ **NOTE:** As a result of the COVID-19 PHE, CMS is no longer requiring payment reviews to be conducted by Cycle 1 states (January 1, 2019 – December 31, 2019 review year), Cycle 2 states (January 1, 2020 – December 31, 2020 review year), and Cycle 3 states (January 1, 2021 – December 31, 2021 review year). This change has been addressed in Section II.B. of the supplemental guidance document that is available on the MEQC website, at <https://www.medicaid.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>

improper payments will be depends on how much time has elapsed between the date of the erroneous eligibility determination in question and the date the pilot review and subsequent payment review are undertaken.

Where eligibility determination errors have resulted in confirmed overpayments, the state should total the number of claims that Medicaid paid for services provided during the three month payment review period, list the total overpayment amount, and provide the estimated amount of FFP that was overpaid. For beneficiaries in risk capitation managed care programs, all Medicaid capitation payments covering the three-month payment review period should likewise be totaled and the estimated amount of FFP calculated. Where a beneficiary was determined eligible but placed in the wrong eligibility group, different types of calculations may have to take place. For example, in the case of beneficiaries placed in the adult expansion group as newly eligible who should have been in a different eligibility group (or in the adult group but not as newly eligible), the state would be expected to calculate the amount of additional FFP paid on Medicaid-covered services that the beneficiary received.

It is possible that states will identify errors that involve underpayments; however, it may not always be possible to identify the sum of these. For example, there is no way to calculate the full amount of Medicaid payments that might have been issued on behalf of a beneficiary enrolled in a MAGI-eligible Medicaid category who should have been eligible for long term care services. The same might be true of a beneficiary placed in a traditional family category who should also have been eligible for tuberculosis-related services. On the other hand, some underpayments can be calculated. For example, this should be possible for beneficiaries placed in a traditional MAGI-based Medicaid category who should have been in the adult expansion group. The table below provides examples of overstated and understated liability with respect to FFP and benefits. When liability is overstated, too much FFP is claimed or too many benefits are conferred. When liability is understated, the converse is true: too little FFP is claimed or too few benefits are conferred.

Table 5: Examples of Overstated/Understated Liability

	Overstated Liability	Understated Liability
FFP Impact	<ul style="list-style-type: none"> Found eligible in Adult group, as a newly eligible but should have been either not newly eligible or eligible in the parent/caretaker relative group 	<ul style="list-style-type: none"> Found eligible for family planning, should have been found eligible for Parent/Caretaker relative group Found eligible for the Medicaid children’s group, should have been eligible for CHIP

	<ul style="list-style-type: none"> • Found eligible as a child in CHIP, should have been eligible in the Medicaid children’s group • Found eligible in Adult group, as a newly eligible but should have been eligible in the former foster care group • Determined to be newly eligible in Adult expansion group, should have been eligible in the Pregnant women group 	<ul style="list-style-type: none"> • Found eligible for CHIP, should have been found eligible in the Parent/Caretaker relative group
Benefits Impact	<ul style="list-style-type: none"> • Found in the former foster care group, should have been eligible for family planning • Found eligible for the Aged, Blind and Disabled (ABD) group, should have been eligible as a Specified Low-Income Medicare Beneficiary (SLMB)¹⁵ 	<ul style="list-style-type: none"> • Should have been eligible in the Pregnant women group but was incorrectly restricted to emergency Medicaid, • Found eligible for medically needy spend down, should have been eligible in the ABD group

c. Payment Adjustments¹⁶

After identifying overpayments and/or underpayments through MEQC payment reviews, states are required to tally the overpayments and underpayments that can be calculated from active case errors and report any necessary adjustments on the appropriate lines of the CMS-64 quarterly reports for Medicaid and the CMS-21 quarterly reports for CHIP within the Medicaid Budget and Expenditure System.

Note: While expenditures and adjustments for persons in standalone CHIP programs are reported on the CMS-21 form, there is a different form for reporting expenditures and adjustments for

¹⁵ As defined at 1902(a)(10)(e)(iii) and 1905(p)(3)(A)(ii) of the Social Security Act.

¹⁶ **NOTE:** As a result of the COVID-19 PHE, CMS is no longer requiring payment adjustments to be made by Cycle 1 states (January 1, 2019 – December 31, 2019 review year), Cycle 2 states (January 1, 2020 – December 31, 2020 review year), and Cycle 3 states (January 1, 2021 – December 31, 2021 review year). This change has been addressed in Section II.B. of the supplemental guidance document that is available on the MEQC website, at <https://www.medicaid.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>.

CHIP enrollees in Medicaid expansion programs (MCHIP enrollees). MCHIP expenditures and adjustments should be reported on the CMS-64.21U form.

In a case where expenditures for a CHIP enrollee were reported as Medicaid instead of CHIP, those expenditures would have to be re-classified by removing them from Medicaid using the CMS-64, then reporting them on the appropriate CHIP form. This would be form CMS-64.21U for MCHIP enrollees or the CMS-21 form for CHIP enrollees in standalone programs.

States do not have to wait until the submission of their case level reports (due by August 1 of the year following their MEQC review period) to make adjustments for the over- and/or underpayments found through MEQC payment review. They can make adjustments on a rolling basis in the course of their MEQC pilots if they wish as soon as they confirm that net overpayments or underpayments were found.

G. State Reporting

Under § 431.816 and § 431.820, states must submit case level reports on their MEQC pilot studies and CAPs that address any active or negative case errors, including deficiencies and their root causes, by August 1 following completion of their review period.¹⁷ Comprehensive information about the requirement for case-level reports and CAPs will be provided in a subsequent update of this sub-regulatory guidance.

4. Access to Records Requirements

States should be aware that the MEQC regulations at § 431.818 contain an access to records requirement. This stipulates that “the State, upon written request must submit to . . . HHS staff or other designated entity, all records including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access.” Records that may be requested include information available under 42 CFR 435,

¹⁷ **NOTE:** As a result of the COVID-19 PHE, CMS established revised deadlines and streamlined reporting requirements for case level reports for Cycle 1 states (January 1, 2019 – December 31, 2019 review year), Cycle 2 states (January 1, 2020 – December 31, 2020 review year), and Cycle 3 states (January 1, 2021 – December 31, 2021 review year). The revised deadlines and reporting requirements have been published in Section II of the supplemental guidance document that is available on the MEQC website, at <https://www.medicare.gov/medicaid/eligibility/medicaid-eligibility-quality-control/index.html>.

Subpart I, which deals with the specific eligibility and post-eligibility financial requirements for the medically needy.

Appendix 1: Examples of MEQC Subjects for State Study

Subject	Program		
	Medicaid MAGI	Medicaid Non-MAGI	CHIP
<p><i>Adult Group Enrollment</i> In expansion states, review for appropriateness of enrollment in adult group and accuracy of FMAP claiming (only claiming enhanced FMAP for newly eligible individuals)</p>	X		
<p><i>Income Counting and Household Composition Rules for both MAGI and non-MAGI</i> Review a mix of cases for appropriate application of household composition and income counting rules</p>	X	X	X
<p><i>MAGI – Household composition</i></p> <ul style="list-style-type: none"> • Three-generation households • Family size for a pregnant woman in the HH, depending on state option • Non-Title IV-E foster care children living with no birth siblings and living in a sibling group • Applying tax filer rules • Child/tax dependent exceptions? 	X		
<p><i>MAGI –Income counting</i></p> <ul style="list-style-type: none"> • Counting of Social Security benefits for children/tax dependents • Reasonably predictable changes in future income • Self-employment/business income with a loss or a carry forward of a prior year loss • Counting of VISTA income 	X		

<p><i>Renewal</i></p> <p>Assess timeliness of redetermination and the appropriate use of data sources to attempt to conduct a renewal before requesting additional information from a beneficiary</p> <ul style="list-style-type: none"> • States that implemented an e14 waiver¹⁸ at renewal • Ex parte renewals • Appropriate application of continuous eligibility 	X	X	X
<p><i>Immigrant Eligibility</i></p> <p>Review accuracy of assessment of immigrant eligibility and appropriate verification</p> <ul style="list-style-type: none"> • Five year bar • Mixed immigration-status households • Counting of sponsor deeming income 	X	X	X
<p><i>Verification Documentation</i></p> <p>Review a mix of cases to ensure sufficient documentation appears in the case file to confirm eligibility</p>	X	X	X
<p><i>Systems issues</i></p> <p>Review to determine whether the cascade is working correctly</p> <ul style="list-style-type: none"> • Placement of adults in TMA; placement of children in TMA at the appropriate time • Placement of former foster care youth in the appropriate group in the hierarchy • Enrollment of gap-filling cases correctly in Medicaid • Placement of CHIP-funded children in Medicaid expansion as opposed to a separate CHIP 	X	X	X

¹⁸ This refers to a waiver of the provisions of 1902(e)(14) of the Social Security Act (as created by the Affordable Care Act) that requires states to apply MAGI for income eligibility and other income-dependent determinations (e.g., premium assessment). The Secretary of the U.S. Department of Health & Human Services has the authority to temporarily waive these requirements in Medicaid and CHIP under certain circumstances “to ensure that States establish income and eligibility determination systems that protect beneficiaries.”

<p><i>Enrolling and maintaining coverage for vulnerable populations</i></p> <ul style="list-style-type: none"> • Individuals aging out of foster care- whether transitioned to former foster group • Homeless youth • Non-Title IV-E adoption assistance within a state and moving interstate • Incarcerated individuals or individuals re-entering into the community 	X	X	X (for incarcerated)
<p><i>Family planning group</i></p> <p>Review eligibility determinations to determine:</p> <ul style="list-style-type: none"> • Are MAGI-based methods used for the group? • Is household income calculated correctly where the state elects to vary household size or income counted for the group? • Is family planning group in the correct placement in the eligibility hierarchy? 	X		
<p><i>Institutional eligibility</i></p> <p>Review a mix of active and negative cases, active cases for appropriate calculation of income and assets and appropriate verification, negative cases for correct denial or termination and appropriate notice</p> <ul style="list-style-type: none"> • Where the institutionalized person has a spouse and or children living outside of the institution in the home 		X	
<p><i>Institutional eligibility</i></p> <p>Review a mix of active cases to determine if the Post Eligibility Treatment of Income (PETI) was calculated correctly and there was a proper deduction of incurred medical expenses</p>		X	
<p><i>Institutional eligibility</i></p> <p>Review a mix of active and negative cases to determine if the penalties for transfers of assets (annuities, spousal trusts) were calculated correctly</p>		X	

<i>Spend down</i> Applicants who meet all eligibility requirement except for income. Eligibility occurs when the allowable medical expenses exceed the states income threshold	X (MAGI-like)	X	
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Appendix 2: Structure of State MEQC Planning Document

States must use the following template in organizing their MEQC Planning Documents

- **Page limit:** Maximum 20 pages in length not including cover sheet;
- **Due Date:** Due Nov. 1 in year each PERM review period ends

- Cover sheet
 - Include a cover sheet with quantitative summary of the pilot planning document. A model cover sheet and instructions for completing it are included as Appendix 3 and 4, respectively.

- Section 1: Introduction
 - **Summary Statement:** Include appropriate summary statement of the state's goals in undertaking this pilot, if needed.
 - **Organization Chart:** Include appropriate organization chart(s) as well as a narrative explanation in order to document how the staff undertaking and overseeing the MEQC review are functionally separate from and independent of staff responsible for establishing eligibility policy and undertaking eligibility determinations.
 - **Point of Contact:** Include name, title, address, phone number and email address of a designated MEQC Coordinator.

- Section 2: Active Cases--Medicaid
 - **Entire universe or stratification.** Indicate whether state intends to do a sampling of the entire Medicaid universe of active cases or study different areas of focus in the Medicaid population.
 - **Entire Universe Justification.** If sampling the entire Medicaid universe of active cases, provide justification for this approach and discuss how the universe will be developed.
 - **Active Case Sampling Plan.** Indicate the total universe of active Medicaid cases, confirm time frame over which universe will be calculated, and indicate total Medicaid sample to be selected.
 - **Certification of active case sample size:** Certify that the minimum regulatory requirement of sampling at least 400 active cases will be met, of which at least 200 are Medicaid.
 - **Sampling method:** Explain the method to be used in selecting the sample of active cases from the entire Medicaid universe. This includes a description of the random sampling approach to be used and the frequency with which the

sample of active Medicaid cases will be pulled (monthly, quarterly, etc.). The state should also describe what provision it has made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.

- Case Review Plan/Quality Control: If you sampled the entire Medicaid universe of active cases, describe the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

If you did not sample the entire Medicaid universe of active cases proceed below to the section on “Areas of Focus—Medicaid.”

- Section 3: Active Cases--CHIP
 - Entire Universe or Stratification. Indicate whether state intends to do a sampling of the entire CHIP universe of active cases or study different areas of focus in the CHIP population.
 - Entire Universe Justification. If sampling the entire CHIP universe of active cases, provide justification for this approach and discuss how the universe will be developed.
 - Active Case Sampling Plan. Indicate the total universe of active CHIP cases, confirm time frame over which universe will be calculated, and indicate total CHIP sample of active cases to be selected. **Provide justification if the state has chosen to sample no active CHIP cases.**
 - Sampling method: Explain the method to be used in selecting the sample of active cases from the entire CHIP universe. This includes a description of the random sampling approach to be used and frequency with which the sample of active Medicaid cases will be pulled (monthly, quarterly, etc.). The state should also describe what provision it has made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.
 - Case Review Plan/Quality Control: If you sampled the entire CHIP universe of active cases, describe the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

If you did not sample the entire CHIP universe of active cases proceed below to the section on “Areas of Focus—CHIP.”

- Section 4: Areas of Focus—Medicaid (if applicable)
 - Medicaid Active Cases
 - **Description:** Describe each area of focus to be studied for active Medicaid cases.
 - **Justification:** Provide a short justification for each active case Medicaid area of focus.
 - **Sampling plan.** Describe total universe, sampling time frame, and total sample to be selected for each Medicaid active case area of focus.
 - **Sampling Method:** Describe the sampling method to be used in selecting the sample of Medicaid active cases for each area of focus to be studied (pure random sampling, oversampling for certain kinds of cases, etc.). Describe what provision has been made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.
 - **Frequency of sampling:** Describe the frequency with which the sample of active Medicaid cases will be pulled (monthly, quarterly, etc.).
 - **Case Review Plan/Quality Control:** For each active case area of focus chosen, provide a concise description of the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

- Section 5: Areas of Focus—CHIP (if applicable)
 - CHIP Active Cases
 - **Description:** Describe each area of focus to be studied for active CHIP cases.
 - **Justification:** Provide a short justification for each active case CHIP area of focus.
 - Describe total universe, sampling time frame, and total sample to be selected for each CHIP active case area of focus.
 - **Sampling Method:** Describe the sampling method to be used in selecting the sample of CHIP active cases for each area of focus to be studied (pure random sampling, oversampling for certain kinds of cases, etc.). Describe what provision has been made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.
 - **Case review plan:** For each CHIP active case area of focus chosen, provide a concise description of the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

- Section 6: Negative Case Actions—Medicaid
 - Negative Case Sampling Plan. Indicate the total universe of negative Medicaid cases, discuss how the universe will be developed, confirm the time frame over which the universe will be calculated, and indicate the total Medicaid sample of negative case actions to be selected.
 - Certification of active case sample size: Certify that the minimum regulatory requirement of sampling at least 400 negative cases will be met, of which at least 200 are Medicaid.
 - Sampling method: Explain the method to be used in selecting the random sample of negative case actions from the entire Medicaid universe. Describe what provision has been made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.
 - Frequency of sampling: Describe the frequency with which the sample of negative Medicaid case actions will be pulled (monthly, quarterly, etc.).
 - Case Review Plan/Quality Control: Describe the methodology that will be used to assess whether the selected negative Medicaid case actions were appropriately determined or if errors or deficiencies were identified.

- Section 7: Negative Case Actions—CHIP
 - Negative Case Sampling Plan: Indicate the total universe of negative CHIP cases, discuss how the universe will be developed, confirm the time frame over which the universe will be calculated, and indicate the total CHIP sample of negative case actions to be selected.
 - Certification of active case sample size: Certify that the minimum regulatory requirement of sampling at least 400 negative cases will be met, of which at least 200 are CHIP.
 - Sampling method: Explain the method to be used in selecting the random sample of negative case actions from the entire CHIP universe. Describe what provision has been made for oversampling in case some of the samples chosen include cases that meet exclusion criteria or that are otherwise invalid.
 - Frequency of sampling: Describe the frequency with which the sample of negative CHIP case actions will be pulled (monthly, quarterly, etc.).
 - Case Review Plan/Quality Control: Describe the methodology that will be used to assess whether the selected negative CHIP case actions were appropriately determined or if errors or deficiencies were identified.

- Section 8: Payment Review Process (Active Cases Only)
 - Description: Describe the process the state will use to identify and make adjustments for overpayments or underpayments in all **active** Medicaid and CHIP cases where erroneous eligibility determinations were found.
 - Deficiencies: Describe how the state will confirm that no incorrect payments were in fact made for **active** cases in which deficiencies were identified.

- Conclusion or Summary Statement (Optional)

Appendix 3: MEQC Pilot Planning Cover Sheet

MEQC Pilot Planning document Cover Sheet				
Name of State & Date Submitted→				
Contact Person→				
Phone →				
Email→				
MEQC Review Period	Jan. 1 – Dec. 31, 20__			
Active Cases (minimum of 400 & at least 200 Medicaid required)				
Universe Size (Indicate Medicaid, CHIP, and Grand Total) →				
Time Frame of Universe →				
Total Sample selected (Indicate Medicaid, CHIP, and Grand Total) →				
Active Case Areas of Focus—Medicaid				
Indicate NO here if you have no Medicaid active case areas of focus & skip this section →				
Description Area of Focus 1	Description Area of Focus 2	Description Area of Focus 3	Description Area of Focus 4	Description Area of Focus 5
Universe 1	Universe 2	Universe 3	Universe 4	Universe 5
Sample Size 1	Sample Size 2	Sample Size 3	Sample Size 4	Sample Size 5
Active Case Areas of Focus—CHIP				
Indicate NO here if you have no CHIP active case areas of focus & skip this section →				
Description Area of Focus 1	Description Area of Focus 2	Description Area of Focus 3	Description Area of Focus 4	Description Area of Focus 5
Universe 1	Universe 2	Universe 3	Universe 4	Universe 5
Sample Size 1	Sample Size 2	Sample Size 3	Sample Size 4	Sample Size 5

Negative Cases (minimum of 400 required [200 Medicaid, 200 CHIP])	
Universe Size of Medicaid Negative Case Actions →	
Time Frame of Negative Medicaid Universe →	
Total Number of Medicaid Negative Case Actions to be Selected →	
Planned Frequency of Sampling →	
<hr/>	
Universe Size of CHIP Negative Case Actions →	
Time Frame of Negative CHIP Universe →	
Total Number of CHIP Negative Case Actions to be Selected →	
Planned Frequency of Sampling →	
<hr/>	
Total Universe Size of Medicaid and CHIP Negative Case Actions →	
Grand Total of Medicaid and CHIP Negative Case Actions to be Selected →	

Appendix 4: Instructions for Completing MEQC Pilot Planning Cover Sheet

Instructions for Submitting MEQC Pilot Planning Document with Cover Sheet:

Please submit planning document no later than November 1 of year in which your state's PERM review ends.

The planning document should be submitted electronically to the MEQC mailbox at: CMS-MEQC-Inquiries@cms.hhs.gov.

Be sure that the submission includes the name, address, email and phone number of the MEQC Coordinator.

I. MEQC State Data Information

- a. Enter: Name of the state and the date of planning document submission.
- b. Enter: Contact information as indicated (name of contact, email, phone number).

II. Active Cases:

- a. Enter:
 1. Universe size of Medicaid cases from which samples will be taken.
 2. Universe size of CHIP cases from which samples will be taken.
 3. Total universe of Medicaid and CHIP cases in time frame listed below.
- b. Enter:
 1. Time frame from which the above universes were selected. If there are different time frames for Medicaid and CHIP or if time frame is not the calendar year after the year of proposal submission, please give rationale for this in the pilot planning document.
- c. Enter the total selected sample of:
 1. Medicaid cases.
 2. CHIP cases.
 3. Grand Total of Medicaid and CHIP cases selected (**NOTE:** Grand total must be 400 cases or larger, with at least 200 Medicaid cases).

III. Active Case Areas of Focus - Medicaid

- a. If stratified sampling is done, at least 200 Medicaid active cases must be reviewed.
- b. Enter: Description of each Medicaid area of focus selected.
- c. Enter: Universe size of each Medicaid area of focus selected.
- d. Enter: Sample size of each Medicaid area of focus selected.
- e. If more than 5 Medicaid areas of focus are selected, enter the above information for additional areas on a photocopy of this page that is clearly labeled Medicaid Areas of Focus (Active Cases, cont.).

IV. Active Case Areas of Focus - CHIP

- a. If stratified sampling is done, enter a description of each CHIP area of focus.
- b. Enter: Universe size of each CHIP area of focus selected.
- c. Enter: Sample size of each CHIP area of focus selected.
- d. If more than 5 CHIP areas of focus are selected, enter the above information for additional areas on a photocopy of this page that is clearly labeled CHIP Areas of Focus (Active Cases, cont.).

V. Negative cases

- a. At least 400 cases must be sampled from the entire universe of negative case actions, of which there must be a minimum of 200 Medicaid and 200 CHIP cases.
- b. Enter:
 1. Total number of negative case actions in the Medicaid universe.
 2. Time frame over which the Medicaid negative case actions are sampled. Provide justification if time frame is not the standard MEQC review period.
 3. Proposed number of Medicaid negative case actions to be sampled.
 4. Planned frequency of sampling.
- c. Enter:
 1. Total number of negative case actions in the CHIP universe.
 2. Time frame over which the CHIP negative case actions are sampled. Provide justification if time frame is not the standard MEQC review period.
 3. Proposed number of CHIP negative case actions to be sampled.
 4. Planned frequency of sampling.
- d. Enter:
 1. Overall size of the universe of negative Medicaid and CHIP case actions.
 2. Grand total of negative Medicaid and CHIP case actions selected.

Appendix 5: List of Cycle 1, 2, and 3 PERM States

Cycle 1	Cycle 2	Cycle 3
Arkansas	Alabama	Alaska
Connecticut	California	Arizona
Delaware	Colorado	District of Columbia
Idaho	Georgia	Florida
Illinois	Kentucky	Hawaii
Kansas	Maryland	Indiana
Michigan	Massachusetts	Iowa
Minnesota	Nebraska	Louisiana
Missouri	New Hampshire	Maine
New Mexico	New Jersey	Mississippi
North Dakota	North Carolina	Montana
Ohio	Rhode Island	Nevada
Oklahoma	South Carolina	New York
Pennsylvania	Tennessee	Oregon
Virginia	Utah	South Dakota
Wisconsin	Vermont	Texas
Wyoming	West Virginia	Washington

Appendix 6: Sample Memorandum of Understanding (MOUs) for Purpose of Meeting the “Functional and Physical Separation” Requirements at 42 CFR 431.812(a)

[DATE]

RE: Memorandum of Understanding for MEQC "functional & physical separation" requirements under 42 CFR 431.812(a)

To Whom It May Concern:

The Medicaid Eligibility Quality Control (MEQC) team was established to enhance [State]’s healthcare quality control program by performing independent monthly case reviews of Medicaid and CHIP eligibility determinations. Results of the reviews are shared with [insert Medicaid and CHIP policy and operations office(s)].

It is this State’s intention to have the MEQC team conduct the pilot reviews in compliance with 42 CFR Part 431, Subpart P, Medicaid Eligibility Quality Control Program. [State]’s first full MEQC review would commence in January [year] after acceptance of the MEQC pilot planning document in December [year]. Pursuant to MEQC regulations at 42 CFR 431.812(a), “the agency and personnel responsible for the development, direction, implementation, and evaluation of the MEQC reviews and associated activities must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations.”

In reviewing [State]’s organizational chart for compliance with this MEQC regulation, [State] has determined that the organizational structure of the single state agency does not allow for the MEQC personnel to be “functionally and physically separate” in the manner described by the regulatory requirement. As such, [State] submits this Memorandum of Understanding describing the organizational and/or reporting arrangements that [State] has made in order to ensure compliance with the MEQC regulations at 42 CFR 431.812(a).

The MEQC personnel are located in a separate team within the [insert appropriate Department name and address]. [Insert relevant supervisory chain of command and information describing how the MEQC personnel will maintain independence and objectivity.]

[At the state’s option, the MOU can include here a description of the escalation process that will be used to resolve disputes between the MEQC team, the Eligibility Policy team, and/or the Eligibility Determination unit].